



PEACE OFFICER REFRACTIVE SURGERY CLINICAL EXAMINATION REPORT

Applicants: The California State Personnel Board requires that applicants for peace officer positions who have had refractive eye surgery submit regular reports from their doctors for one year. If you have had or plan to have refractive eye surgery of any kind, please take this package to your doctor. Your doctor is to complete the reports as indicated and mail them directly to the address listed for the Department of Corrections.

**Candidate's
Name:**

PRINT

Last

First

MI

Address:

Street

City

State

ZIP

SSN:

Telephone Number:

()

CLASSIFICATION:

(Circle One)

CO

MTA

CCI

PAI

AUTHORIZATION TO RELEASE INFORMATION

To determine my eligibility for employment as a Peace Officer with the California Department of Corrections (CDC), I authorize you to release to CDC any and all medical information and/or records concerning my vision. This authorization is valid until the selection process is completed.

**Candidate's
Signature:**

Date:



REFRACTIVE EYE SURGERY EVALUATION CRITERIA

To Optometrist/Ophthalmologist:

Your patient is seeking employment as a peace officer, a public safety position. He/she has informed us that he/she has undergone or plans to undergo refractive surgery (i.e., RK, PRK, Lasik, laser, etc.) He/she must demonstrate stable visual function prior to appointment as follows:

1. Visual acuity in each eye must be stable over at least a 12-month period of time after surgery.
2. Visual acuity must meet the corrected and uncorrected standard for the class being tested.
3. Glare disability and contrast sensitivity must be normal.
4. Post-operative complications must have been resolved for at least six months.
5. On behalf of your patient, please supply the information requested below when the Clinical Examination Reports document stability.
 - A. Submit a copy of the operative reports and copies of all doctor's progress notes since surgery.
 - B. List date(s) of surgery on each eye.
 - C. List date that applicant became free of post-operative complications.
 - D. List the surgical protocol followed (i.e., Saulson, Thorton, Ellis, other—please name) and a description of the protocol.
 - E. List sensitivity to any environmental factors (i.e., heat, cold, smog, dust, etc.)
 - F. Submit the completed Clinical Examination Report.

The information will be used to determine stability of vision after refractive surgery. Visual acuity should be measured using a Bailey-Lovie acuity chart or other standardized chart used for acuity measurements. Acuity should be measured in the morning and again in the late afternoon (at least 6 hours between exams). Percent glare disability should be measured in each eye before and after cyclopegia. Please list the instrument used and the expected normal values. All post-operative examinations must be at least three months apart for our purposes (this protocol does not preclude other examinations if you determine they are necessary). Cyclopegic exams should be performed after using 1% mydracyl for paralysis of accommodation.

Please send the reports to: California Department of Corrections
Attn: Preemployment Medical Unit
2201 Broadway
Sacramento, CA 95818-2572



Exam Date: _____

PRE-OPERATIVE CLINICAL EXAMINATION REPORT

Applicant: _____
Social Security Number: _____

Examiner: _____
Address: _____
Telephone Number: _____

1. Visual Acuity* (Dimly lit room)
Without Correction OD _____ OS _____
With Correction OD _____ OS _____

2. Manifest Refraction
OD _____
OS _____

3. Tonometry
OD _____ OS _____
OD _____ OS _____

*Please specify method used to measure acuity: _____

| | | |
|-----------------------------|--|----------------------|
| Doctor's Original Signature | | Date |
| Doctor's Printed Name | | Telephone Number |
| Doctor's Address | | City, State Zip Code |



Exam Date: _____

Surgery Dates

Right eye: _____

Left eye: _____

POST-OPERATIVE CLINICAL EXAMINATION REPORT #1 (Six Months)

Applicant: _____

Examiner: _____

Social Security
Number: _____

Morning Exam

Afternoon Exam*

1. Visual Acuity**

(Dimly lit room)

Without Correction

OD _____ OS _____ OD _____ OS _____

With Correction

OD _____ OS _____ OD _____ OS _____

2. Manifest Refraction

OD _____ OS _____ OD _____ OS _____

OS _____ OS _____ OD _____ OS _____

3. Tonometry

OD _____ OS _____ OD _____ OS _____

OD _____ OS _____ OD _____ OS _____

4. Cycloplegic Exam***

A. Pupillary Size

OD _____ OS _____

B. Refraction after
cycloplegia

OD _____ OS _____

C. Slit lamp exam

*Please allow six hours between morning and afternoon exam.

**Please specify method used to measure acuity: _____

***Use 1% mydriacyl for cycloplegia.

| | | |
|-----------------------------|----------------------|------|
| Doctor's Original Signature | | Date |
| Doctor's Printed Name | Telephone Number | |
| Doctor's Address | City, State Zip Code | |



Exam Date: _____

Surgery Dates

Right eye: _____

Left eye: _____

**POST-OPERATIVE CLINICAL EXAMINATION REPORT #2
(Nine Months)**

Applicant: _____

Examiner: _____

Social Security
Number: _____

Morning Exam

Afternoon Exam*

2. Visual Acuity**
(Dimly lit room)
Without Correction

OD _____ OS _____ OD _____ OS _____

With Correction

OD _____ OS _____ OD _____ OS _____

5. Manifest Refraction

OD _____ OS _____

OS _____ OS _____

6. Tonometry

OD _____ OS _____ OD _____ OS _____

OD _____ OS _____ OD _____ OS _____

7. Cycloplegic Exam***

D. Pupillary Size

OD _____ OS _____

E. Refraction after
cycloplegia

OD _____ OS _____

F. Slit lamp exam

*Please allow six hours between morning and afternoon exam.

**Please specify method used to measure acuity: _____

***Use 1% mydriacyl for cycloplegia.

| | | |
|-----------------------------|--|----------------------|
| Doctor's Original Signature | | Date |
| Doctor's Printed Name | | Telephone Number |
| Doctor's Address | | City, State Zip Code |



Exam Date: _____

Surgery Dates

Right eye: _____

Left eye: _____

**POST-OPERATIVE CLINICAL EXAMINATION REPORT #3
(12 Months)**

Applicant: _____

Examiner: _____

Social Security
Number: _____

Morning Exam

Afternoon Exam*

3. Visual Acuity**
(Dimly lit room)
Without Correction

OD _____ OS _____ OD _____ OS _____

With Correction

OD _____ OS _____ OD _____ OS _____

8. Manifest Refraction

OD _____ OS _____

OS _____ OS _____

9. Tonometry

OD _____ OS _____

OD _____ OS _____

10. Cycloplegic Exam***

G. Pupillary Size

OD _____ OS _____

H. Refraction after
cycloplegia

OD _____ OS _____

I. Slit lamp exam

*Please allow six hours between morning and afternoon exam.

**Please specify method used to measure acuity: _____

***Use 1% mydriacyl for cycloplegia.

| | | |
|-----------------------------|--|----------------------|
| Doctor's Original Signature | | Date |
| Doctor's Printed Name | | Telephone Number |
| Doctor's Address | | City, State Zip Code |